City of Riverside
Administrative Manual

Effective Date: 07/2009
Review Date: 07/2012
Prepared by: City Mgr/Finance

Approved:

Department

City Manager

SUBJECT:

Municipal Liability Claims Procedure

PURPOSE:

To establish a procedure for processing claims against the City for damages to property and/or personal injuries alleged to be caused by negligence on the part of the City.

POLICY:

It is the responsibility of all supervisory personnel to establish and maintain safe working methods, conditions, equipment, and City property so as to minimize claims.

Claim forms may be obtained from the City Clerk. The completed form should be delivered to the City Clerk within six months of the occurrence giving rise to the claim. See California Government Code Section 911.2.

If the claimant fails to present the claim within six months, application may be made to the City for leave to present a late claim. See Government Code Sections 911.4 through 912.2. If the application is denied, claimant must file a petition for relief with the appropriate court. See Government Code Section 946.6.

Upon receipt of a claim, the City Clerk will forward copies directly to the City Attorney and the Risk Manager. The Risk Manager will forward the claim to the City's Claims Administrator. The Risk Manager will normally determine which City department(s) should respond to the claim, send a copy to the appropriate department and request a response to the Risk Manager. The Risk Manager, the Claims Administrator, and in appropriate cases, the City Attorney, shall review each claim or application and determine the appropriate action to be taken by the City. The Risk Manager shall be responsible for issuing the appropriate notice to each claimant.

The City employees involved in the occurrence giving rise to the claim should cooperate with the City's Risk Manager and/or the City's Claims Administrator and/or the City Attorney and/or the City's defense attorneys by furnishing them with any additional information that is requested. Failure to cooperate in good faith may lead to the City's refusal to defend and indemnify the involved City employee(s) in the event of litigation.

If reasonably possible, responsible employees shall prepare the City of Riverside incident report in instances where there is damage or injury which may result in a claim. The original incident report shall be forwarded to the Risk Manager and a copy to the employee's immediate supervisor. In cases of severe injury or damage, the City Attorney and the Risk Manager should be contacted immediately.

PROCEDURE:

Responsibility	Action
City Employee	1. Prepares City of Riverside Incident Report when there is damage or injury which may result in a claim. If the employee is unable to prepare the report, his or her supervisor will do so. Report forms are available in each department. 2. Submits the original Incident Report to the Risk Manager with a copy to his or her immediate supervisor.
Claimant	1. Obtains claim form from the City Clerk. 2. Prepares claim form. 3. Delivers or mails the completed claim to the City Clerk within six months of the occurrence giving rise to the claim. 4. Delivers or mails an application with the City for leave to file a late claim if the six-month deadline is not met. If the application is denied, files a petition with the Court for relief from the claim filing requirements.
City Clerk	1. Receives claim or application, forwards copies to the City Attorney and the Risk Manager and retains the original in the Clerk's files. 2. Receives petition for relief from the claim filing requirements and forwards original to the City Attorney and a copy to the Risk Manager.
Risk Manager	1. Sends copy of the claim or application to the City's Claims Administrator. 2. Determines which City department(s) should respond to the claim and sends copy of claim to the department for response to the Risk Manager. 3. Reviews each claim or application in consultation with the Claims Administrator, and in appropriate cases, with the City Attorney, and determines the appropriate action to be taken by the City. Issues the appropriate notice to the claimant. 4. Approves or disapproves settlement of claims for $5,000 or less.
Involved Department	1. Prepares a response to the claim and forwards the response to the Risk Manager.
Claims Administrator	1. Investigates claim, recommends action to be taken and sends a report to the Risk Manager and in appropriate cases, to the City Attorney. Claims involving catastrophic injury shall also be reported by the Claims Administrator to the City Attorney and the City's liability excess insurance carrier.
City Attorney	1. In appropriate cases, reviews claims and/or applications and determines the appropriate response to the claim in consultation with the Risk Manager and the Claims Administrator. Investigates claim and recommends City action in appropriate cases. 2. Approves or disapproves settlement of claims for $15,000 or less. 3. Forwards the settlement authority request report to the City Manager for claims greater than $15,000 up to $25,000 and the City Council for appropriate action for claims in excess of $25,000.
City Manager	1. Approves or disapproves settlement of claims for $25,000 or less.
City Council	1. Approves or disapproves settlement of claims in excess of $25,000.

Attachments:

1. Claim Form 1232.101
2. Incident Report Form

SUPERVISOR'S FIRST REPORT OF INCIDENT / MISHAP

PLEASE PRINT – ***SUBMIT IMMEDIATELY***
COMPLETE HIGHLIGHTED ITEMS TO DOCUMENT FIRST AID INCIDENT ONLY

SUPERVISOR SECTION

Employee: Dept/Div: Classification:

Address: City: Zip: Home Phone:

Birth Date: Age: M ☐ F ☐ Date of Hire: Shift: Day ☐ Evening ☐ Night ☐

Date of Incident: Time of Incident: AM ☐ PM ☐ Time reported to work: Date: Time: AM ☐ PM ☐

Date Incident Reported: Reported to Whom?

Location of Incident:

Type of Incident: Injury ☐ Property Damage ☐ Equipment Damage ☐ Vehicle Collision ☐ Near-Miss ☐

(1) Was employee given 1st Aid Yes ☐ No ☐ (2) Was treatment refused by employee Yes ☐ No ☐

Notify Workers' Compensation for "YES" answers to Items #3, #4 & #5

(3) Was employee sent to: Emergency Room Yes ☐ No ☐ Name of Hospital: _____
Preferred Clinic Yes ☐ No ☐ Name of Clinic: _____
Pre-designated Physician Yes ☐ No ☐ Name of Physician: _____
Other _____

(4) Was employee admitted to hospital? Yes ☐ No ☐ (5) Fatality? Yes ☐ No ☐

Did employee wear protective equipment? Yes ☐ No ☐ List equipment used: _____

Part of Body
☐ No Injury
☐ Fill in Blank (be specific)
_____

Type of Injury (check)
☐ Reaction to foreign substance/object ☐ Contusion ☐ Fracture
☐ Puncture ☐ Burn ☐ Amputation
☐ Loss of Consciousness ☐ Sprain / Strain ☐ Laceration
☐ Chemical Exposure ☐ OPIM Exposure
☐ Other _____ ☐ Abrasion

Incident Cause (check)
☐ Fall from stairs / obstacle / elevation ☐ Act or procedure ☐ Injury from falling objects ☐ Back injury from lifting
☐ Defective equipment ☐ Fall on floor / surface ☐ Improper use of equipment / instrument
☐ Horseplay ☐ Repetitive Motion
☐ Other _____

Witnesses
(1) Name: _____ Dept/Address: _____ Phone: _____
(2) Name: _____ Dept/Address: _____ Phone: _____

City Vehicle Information: Year/Make/Model_____ Type Vehicle _____ Asset# _____
Headlights on? Yes ☐ No ☐ Warning Lights on? Yes ☐ No ☐ Turn signals used? Yes ☐ No ☐ Horn used?: Yes ☐ No ☐
Seatbelts Worn? Driver? Yes ☐ No ☐ Passenger? Yes ☐ No ☐ Police Report # _____ Reporting Agency _____

Other Vehicle Information: (if applicable)
Driver Name: _____ Address _____ City _____ Phone _____
Driver's License # _____ Vehicle Year _____ Make _____ Model _____ Vehicle License # _____
Insurance Company: _____ Policy # _____

Damages: List all damage to property, equipment and/or vehicles: _____

Select conditions present at time of incident:

Environment (Internal / External)
☐ Sunny ☐ Rain
☐ Bright sun / glare ☐ Night
☐ Cloudy / fog ☐ Dusk / dawn
☐ Windy ☐ Other _____
☐ Hot or Cold

☐ Equipment / Materials
☐ Tire condition ☐ Lights inoperative ☐ Lubrication ☐ Corroded
☐ Belt condition ☐ Insulation failure ☐ Belt adjustment ☐ Leaking hose / fitting
☐ Improper adjustment ☐ Loose / missing hardware ☐ Guards defect / missing
☐ Incorrect tool ☐ Defective materials ☐ Incorrect materials
☐ Improper design / type ☐ Other _____

Facility
☐ Layout of equipment ☐ Floors wet / uneven
☐ Housekeeping ☐ Ventilation
☐ Lighting ☐ Other _____

Personnel
☐ Fatigue ☐ Insufficient training ☐ Improper work practice ☐ PPE not used
☐ Action of other(s) ☐ Other _____

Form No. 1210.041 (8/03)

SUPERVISOR'S FIRST REPORT OF INCIDENT / MISHAP

ATTACH ADDITIONAL SHEETS OF PAPER AS NEEDED FOR NARRATIVES

EMPLOYEE SECTION

Employee statement on how incident occurred: ☐ check box if statement is attached

Employee statement on how recurrence could be prevented: ☐ check box if statement is attached

SUPERVISOR SECTION

Describe in detail what employee was doing at time of incident (what, how, why): ☐ check box if statement is attached

Describe what act / condition(s) contributed to the incident (i.e. improper use of equipment, wet floor, etc.): ☐ check box if statement is attached

Supervisors conclusions: ☐ check box if statement is attached

Supervisors recommendation(s) to prevent recurrence: (Type of training, repair/replace equipment, etc.) ☐ check box if statement is attached

Employee's Signature: _____ **Date:** _____

Supervisor's Signature: _____ **Date:** _____

Superintendent/ Manager Signature: _____ **Date:** _____

Distribution: City Safety Officer (Original)
Department / Division (File copy)

Safety Officer will route copies as needed

FIRE / POLICE DEPARTMENT
SUPERVISOR'S FIRST REPORT OF INCIDENT / MISHAP

PLEASE PRINT – *COMPLETE ALL ITEMS IN BOX 1 – FORM SUBMITTED TO WORKERS' COMP* ***– SUBMIT IMMEDIATELY***

COMPLETE HIGHLIGHTED ITEMS TO DOCUMENT FIRST AID INCIDENT ONLY

SUPERVISOR SECTION

Employee: Dept/Div: Classification:

Address: City: Zip: Home Phone:

Birth Date: Age: M ☐ F ☐ Date of Hire: Shift: Day ☐ Evening ☐ Night ☐

Date of Incident: Time of Incident: AM ☐ PM ☐ Time reported to work: Date: Time: AM ☐ PM ☐

Date Incident Reported: Reported to Whom?

Location of Incident:

Type of Incident: Injury ☐ Property Damage ☐ Equipment Damage ☐ Vehicle Collision ☐ Near-Miss ☐

(1) Was employee given 1st Aid Yes ☐ No ☐ (2) Was treatment refused by employee Yes ☐ No ☐

Notify Workers' Compensation for "YES" answers to Items #3, #4 & #5

(3) Was employee sent to: Emergency Room Yes ☐ No ☐ Name of Hospital: _____

Preferred Clinic Yes ☐ No ☐ Name of Clinic: _____

Pre-designated Physician Yes ☐ No ☐ Name of Physician: _____

Other _____

(4) Was employee admitted to hospital? Yes ☐ No ☐ (5) Fatality? Yes ☐ No ☐

Did employee wear protective equipment? Yes ☐ No ☐ List equipment used: _____

Part of Body

☐ No Injury
☐ Fill in Blank (be specific)
_____

Type of Injury (check)

☐ Reaction to foreign substance/object
☐ Puncture
☐ Loss of Consciousness
☐ Chemical Exposure
☐ Other _____
☐ Contusion
☐ Burn
☐ Sprain / Strain
☐ OPIM Exposure
☐ Abrasion
☐ Fracture
☐ Amputation
☐ Laceration

Incident Cause (check)

☐ Fall from stairs / obstacle / elevation
☐ Defective equipment
☐ Horseplay
☐ Other _____
☐ Act or procedure
☐ Fall on floor / surface
☐ Repetitive Motion
☐ Injury from falling objects
☐ Improper use of equipment / instrument
☐ Back injury from lifting

Witnesses

(1) Name: _____ Dept/Address: _____ Phone: _____

(2) Name: _____ Dept/Address: _____ Phone: _____

City Vehicle Information: Year/Make/Model_____ Type Vehicle _____ Asset# _____

Headlights on? Yes ☐ No ☐ Warning Lights on? Yes ☐ No ☐ Turn signals used? Yes ☐ No ☐ Horn used?: Yes ☐ No ☐

Seatbelts Worn? Driver? Yes ☐ No ☐ Passenger? Yes ☐ No ☐ Police Report # _____ Reporting Agency _____

Other Vehicle Information: (if applicable)

Driver Name: _____ Address _____ City _____ Phone _____

Driver's License # _____ Vehicle Year _____ Make _____ Model _____ Vehicle License # _____

Insurance Company: _____ Policy # _____

Damages: List all damage to property, equipment and/or vehicles: _____

Select conditions present at time of incident:

Environment (Internal / External)

☐ Sunny
☐ Bright sun / glare
☐ Cloudy / fog
☐ Windy
☐ Hot or Cold
☐ Rain
☐ Night
☐ Dusk / dawn
☐ Other _____

☐ Equipment / Materials

☐ Tire condition ☐ Lights inoperative ☐ Lubrication ☐ Corroded
☐ Belt condition ☐ Insulation failure ☐ Belt adjustment ☐ Leaking hose / fitting
☐ Improper adjustment ☐ Loose / missing hardware ☐ Guards defect / missing
☐ Incorrect tool ☐ Defective materials ☐ Incorrect materials
☐ Improper design / type ☐ Other _____

Facility

☐ Layout of equipment
☐ Housekeeping
☐ Lighting
☐ Floors wet / uneven
☐ Ventilation
☐ Other _____

Personnel

☐ Fatigue ☐ Insufficient training ☐ Improper work practice ☐ PPE not used
☐ Action of other(s) ☐ Other _____

Form No. 1210.042 (8/03)

FIRE / POLICE DEPARTMENT
SUPERVISOR'S FIRST REPORT OF INCIDENT / MISHAP

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Supervisors conclusions: ☐ check box if statement is attached

Supervisors recommendation(s) to prevent recurrence: (Type of training, repair/replace equipment, etc.) ☐ check box if statement is attached

Employee's Signature: _____ **Date:** _____

Supervisor's Signature: _____ **Date:** _____

Superintendent/ Manager Signature: _____ **Date:** _____

Distribution: City Safety Officer (Original)
Department / Division (File copy)

Safety Officer will route copies as needed

CITY OF RIVERSIDE

FILE WITH:

City Clerk's Office
City of Riverside
3900 Main Street
Riverside, CA 92522

CLAIM FOR DAMAGES

TO PERSON OR PROPERTY

RESERVE FOR FILING STAMP

INSTRUCTIONS

1. Claims for death, injury to person or to personal property must be filed not later than six (6) months after the occurrence. (Gov. Code Sec. 911.2.)
2. Claims for damages to real property and claims for monies purportedly owned by the City such as refunds and contract damages (Loss) must be filed not later than one (1) year after the occurrence. (Gov. Code Sec. 911.2; Chapter 1.05, Riverside Municipal Code.)
3. Read entire claim form before filing.
4. See page 2 for diagram upon which to locate place of accident.
5. This claim form must be signed on page 2 at bottom.
6. Attach separate sheets, if necessary, to give full details. SIGN EACH SHEET

TO: **CITY OF RIVERSIDE**

Date of Birth of Claimant

Name of Claimant

Occupation of Claimant

Home Address of Claimant — City and State

Home Telephone Number

Business Address of Claimant — City and State

Business Telephone Number

Give address and telephone number to which you desire notices or communications to be sent regarding this claim:

Claimant's Social Security Number

When did DAMAGE, INJURY, or LOSS occur?
Date _____ Time _____
If claim is for Equitable Indemnity, give date claimant served with the complaint.
Date: _____

Names of any City employees involved in DAMAGE, INJURY, or LOSS

Where did DAMAGE, INJURY, or LOSS occur? Describe fully, and locate on diagram on reverse side of this sheet. Where appropriate, give street names and addresses and measurements from landmarks:

Describe in detail how the DAMAGE, INJURY, or LOSS occurred.

Why do you claim the City is responsible?

Describe in detail each DAMAGE, INJURY, or LOSS

SEE PAGE 2 (OVER)

THIS CLAIM MUST BE SIGNED ON REVERSE SIDE